THE NEED FOR ADDITIONAL FUNDS FOR FAMILY PLANNING IN SUB-SAHARAN AFRICA

Summary

This brief on the assessment of financing needs is followed by three additional briefs that examine ways of mobilizing additional resources or reducing service costs.

This brief takes a look at the need for family planning funding in sub-Saharan Africa by:

- estimating current and future needs for family planning services;
  estimating the costs of meeting these needs;
- estimating the amount of family planning funding currently provided by donors and governments;
- examining the sources of funding for family planning; and
- examining the arguments for and against donor and government subsidies for contraceptive services.

Beryl Goldberg

QUESTION #1:

What are the needs for family planning in sub-Saharan Africa?

Almost 10 million sub-Saharan African women currently use family planning. Three times this number — about 29 million women — have an unmet need for family planning services. Total family planning needs equal the sum of current use and unmet need. Unmet need for contraceptive services is defined here as the number of women of reproductive age who are biologically able to have children and wish to stop or delay childbearing, but who are not using contraceptives. To the extent that some of these women would rather risk an unwanted pregnancy than use contraception, conventional unmet need figures overstate needs as defined by individuals.

The proportion of women of reproductive age who are currently using contraception or who have an unmet need for family planning in a range of sub-Saharan African countries is shown in Figure 1.[1] In several countries — Botswana, Kenya, Namibia, Togo and Zimbabwe — more than 20 percent of women of reproductive age have an unmet need for family planning services.

The need for family planning services in sub-Saharan Africa is on the rise because:

- the population is growing, and women of reproductive age make up a greater and greater share of this population; and
- a larger percentage of women want to use contraception.

QUESTION #2:

What will it cost to meet the current and projected need for family planning services?

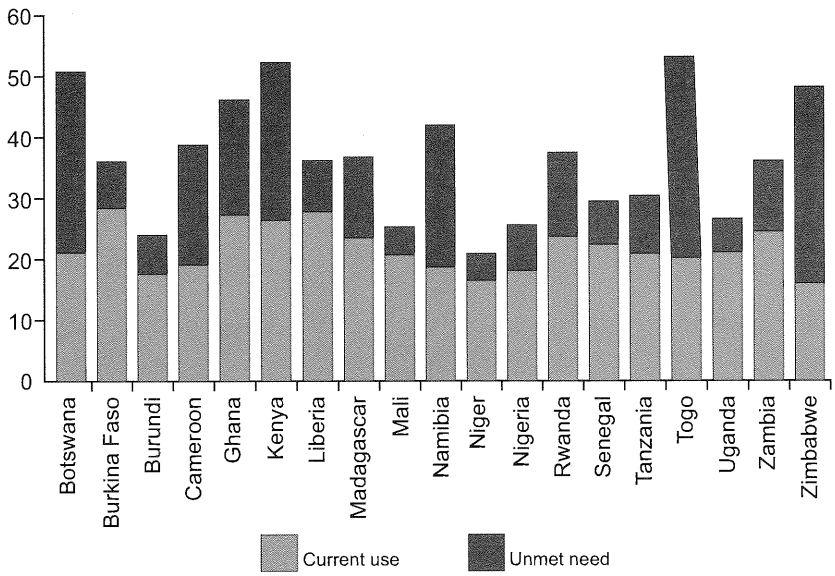
How much would it cost to meet current and unmet need today?

Providing services to the approximately 29 million women defined to be in unmet need — in addition to continuing to provide services to current contraceptive users — would cost about U.S. $841 million, or about three times the amount currently spent on family planning services in the region.

What will it cost to meet all future needs?

Determining the amount of funding required to meet future family planning needs is a difficult exercise. The most recent estimates were developed by the United Nations Population Fund (UNFPA)[2] and are shown in Figure 2.

Figure 1. Current Use of and Unmet Need for Family Planning among All Women Regardless of Marital Status, 1987-1993 (percentage)



Source: Westoff and Bankole, 1995.

According to the UNFPA estimates, annual resource requirements for family planning will grow significantly over the next several years, reaching almost U.S. $3 billion by 2015. These are resources required to provide basic family planning services only. Providing a broader range of reproductive health services increases total requirements substantially (see Box 1).

Box 1. Costs of providing basic reproductive health care

The UNFPA has estimated the costs of providing the following aspects of basic reproductive health care at the primary care level: prenatal, normal and safe delivery and post-natal care; adequate counseling; prevention of infertility, and appropriate treatment, where feasible; prevention, diagnosis, and treatment of sexually transmitted diseases and other reproductive tract infections, as feasible; prevention and treatment of other reproductive health conditions; information, education, and counseling, as appropriate, on human sexuality, sexual and reproductive health, and responsible parenthood; and active discouragement of harmful practices against girls and women, such as female genital mutilation.

In 2000, the total estimated annual resource requirements for both family planning and reproductive health care will be almost U.S. $2 billion[3] — over 65 percent more than the amount required to finance family planning services alone. By the year 2015, total requirements will be almost U.S. $4 billion. Due to the inadequacy of available information on the costs of providing reproductive health care, these figures should be interpreted as minimum estimates.

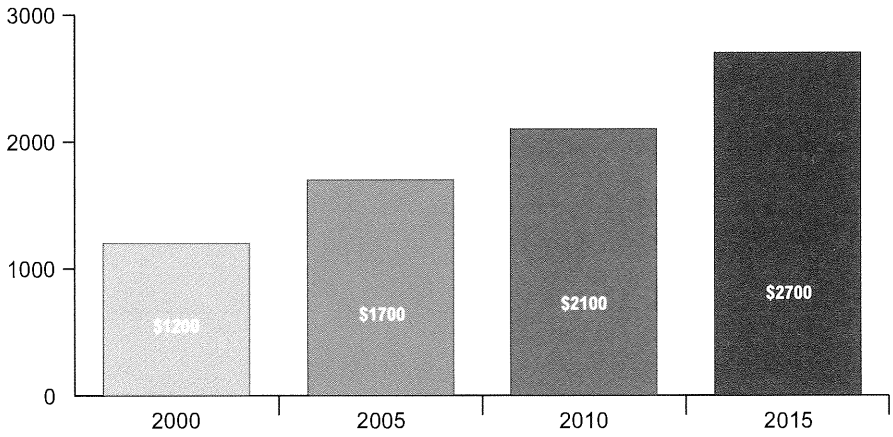
Because a great deal of the information needed to develop accurate resource requirement estimates is not available, these figures are very rough. They are likely to underestimate true resource needs. There is an urgent need to assess true resource requirements at the country level. Until then, we will have a very poor idea of the actual amounts required to provide contraceptive services to all who need them.

QUESTION #3:

How are family planning services financed in sub-Saharan Africa today?

Family planning services are financed using donor funds, local country tax revenues, and client fees. The funding mix varies according to the type of service provider. For example, pharmacies and other shops that provide contraceptives tend to cover their costs using revenues from sales to clients. Social marketing programs also provide contraceptives at pharmacies and shops. However, some of the funding for these particular products may be provided by donors or tax revenues, with clients paying only a portion of the costs. Indeed, purely commercial family planning activities are very rare in the sub-Saharan region; donors provide at least some funding for most retail contraceptive services. Ministry of health facilities may use a combination of client fees for services, donor funds, and tax revenues. Nongovernmental facilities are most often supported with a combination of donor funds and fees for services.

Figure 2. Total Estimated Annual Resource Requirements for Family Planning in Sub-Saharan Africa, 2000-2015 (millions of U.S. dollars)



Source: UNFPA, 1996b.

QUESTION #4:

What are the trends in donor funding for family planning in sub-Saharan Africa?

What do we know about donor funding for family planning worldwide?

Donor funding for family planning worldwide has grown at a steady pace for much of the last decade. Between 1985 and 1994, donor funding grew by an average of 5 percent per year in real terms (adjusted for inflation).[4] Between 1993 and 1994, donor funding for family planning services grew by 24 percent. This acceleration in the growth of funding likely is due to the impact of the International Conference on Population and Development (ICPD) held in Cairo in 1994.

Box 2. Types of family planning activities funded by donors

While we have a fairly clear idea of the total amount of donor funding for family planning in sub-Saharan Africa through 1994, we have very little information on the specific types of family planning activities these funds have supported. For example, we do not know with any certainty the amounts spent on contraceptive services, family planning education, or population research. This information is important, since one can argue that donor funds should be used to support infrastructure, training, and other activities that will help countries finance their own services in the future.

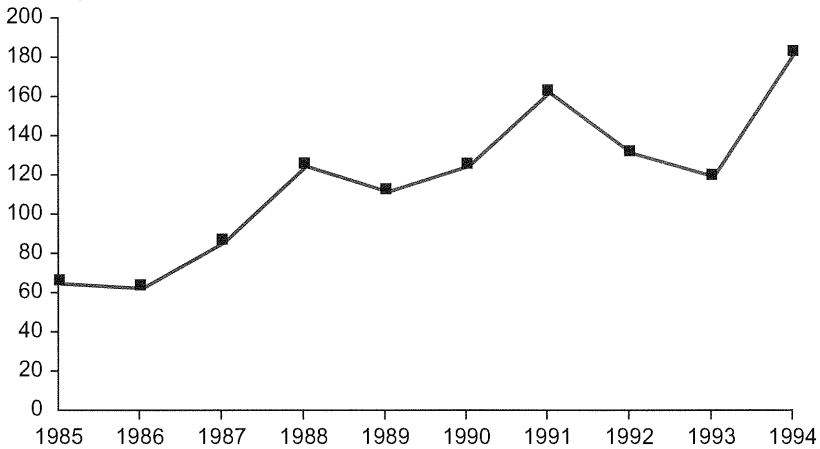
In 1995, UNFPA adopted a new definition of population assistance that includes funding for family planning as well as a range of other reproductive health services. Total funding for family planning and reproductive health care grew by 22 percent between 1994 and 1995,[5] but this appears to be due to the addition of a broader range of services to the definition. In fact, it is possible that funding for conventional family planning services declined between 1994 and 1995.

While the increases in funding from some donor countries between 1994 and 1995 were allocated almost entirely to family planning services, other donor countries focused almost exclusively on increasing allocations for broader reproductive health care. Almost 85 percent of the growth in U.S. funding, for example, was for family planning.[6] By comparison, less than 20 percent of the increase in the contribution from the United Kingdom was for family planning.

What do we know about trends in donor funding to sub-Saharan Africa?

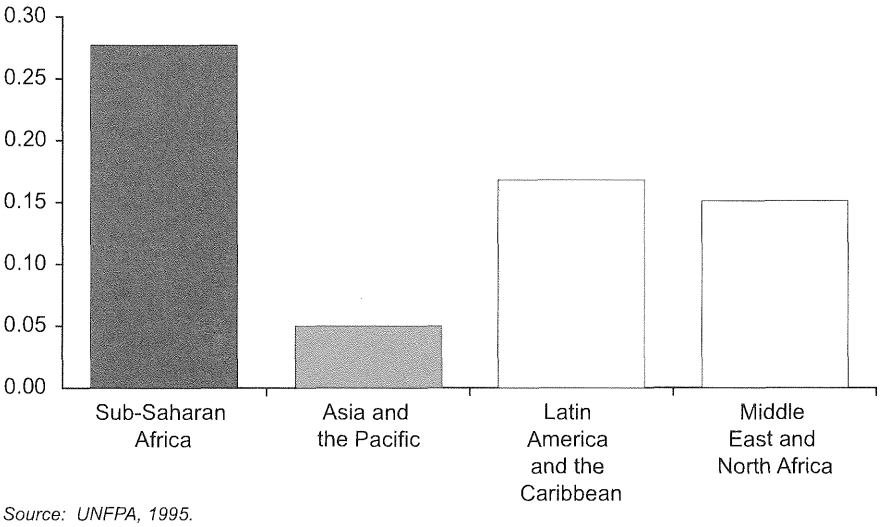
In sub-Saharan Africa, the growth of population funding through 1994 was even more pronounced than in the world as a whole. Annual donor spending on family planning activities jumped 52 percent between 1993 and 1994.[7] During the decade 1985-1994, the growth in final expenditures for population assistance averaged 14.5 percent per year (see Figure 3).

Figure 3. Final Expenditures for Population Assistance, Sub-Saharan Africa, 1985-94 (millions of constant U.S. dollars)



Source: UNFPA, 1996a.

Figure 4. Final Expenditures for Population Assistance Per Capita, by Region, 1993 (U.S. dollars)



Source: UNFPA, 1995.

Regional increases in donor funding for family planning and reproductive health care between 1994 and 1995 were also substantial, at 43 percent.[8] Again, however, it is unclear how much of the increased funding was for family planning services versus other elements of reproductive health care.

Sub-Saharan Africa also receives more population funding per capita than any other region at nearly U.S. $0.30 per person (see Figure 4). Per capita expenditures doubled between 1984 and 1993.[9]

How does the ratio of donor funding to total funding in sub-Saharan Africa compare with other developing regions?

The proportion of total family planning expenditure made up by donor contributions is far higher in sub-Saharan Africa than in any other developing region, as illustrated in Table 1.

Donor funds cover 54 percent of all family planning funding in the region.[10] The next highest proportional contribution is in North Africa and West Asia, at only 27

Table 1. Source of Family Planning Expenditure, by Region (percentage)

Region	*Donors*	*World Bank*	*Government*	*Consumers*
Sub-Saharan Africa	53.9	10.1	22.3	13.7
Sub-Saharan Africa (excluding South Africa)	71.2	13.3	8.7	6.7
East and Southeast Asia	3.5	1.6	88.1	6.8
South Asia	15.6	23.8	55.2	5.4
Latin America and the Caribbean	21.6	2.0	27.8	48.6
North Africa and West Asia	26.7	5.7	36.0	31.6
All Developing Regions	13.9	7.0	65.4	13.7

Source: Conly et al., 1995.

percent. The donor contribution in sub-Saharan Africa is actually far higher than 54 percent, since South Africa — which accounts for most overall spending but has only recently begun to receive donor contributions — is included in the estimate. The donor contribution to all other sub-Saharan countries is more than 70 percent. If World Bank loans — many of which are provided at concessionary interest rates — are included, the total donor contribution rises to 85 percent.

QUESTION #5:

What do we know about government funding of family planning in sub-Saharan Africa?

It is very difficult to estimate the amount of money governments spend on family planning services. This is because family planning budgets tend to be part of overall health care budgets, and it is difficult to determine the precise amounts spent on specific types of services within these budgets. In addition, information on government spending is often not available at the central level, so it must be collected directly from facilities — a very cumbersome task.

Because of these difficulties, there is very little accurate information available on government spending on family planning. Often, very different estimates exist for the same country, depending on the method used to collect the information. Two estimates of annual government family planning spending in Côte d'Ivoire, Ghana and Kenya are presented in Table 2. The second estimates provided for each country were derived from the responses of key informants to questionnaires soliciting information on government spending,[11] while the first were developed using a more in-depth approach, which should provide more accurate estimates of spending. While even the estimates from the more detailed country-level studies are flawed, due to data limitations and difficulties of estimation, this is the preferred approach.

Table 2. Country-Level Government Expenditure on Family Planning

Country	Expenditure (U.S. dollars)	
	In-depth	*Questionnaire*
Ghana	$3,770,491[12]	$2,100,000[13]
Kenya	$2,195,125[14]	$800,000[15]
Côte d'Ivoire	$120,172[16]	$100,000[17]

It is clear from Table 2 that there is an urgent need for detailed, country-level studies of government family planning spending.

How does government spending in Africa compare with that in other regions?

While available information on government family planning spending is very rough, it appears likely that governments make a lesser contribution to family planning in sub-Saharan Africa than they do in other regions. In more than half of the 35 sub-Saharan African countries for which this information is available, the government contributes less than 10 percent of the total; in nine sub-Saharan African countries, the government contributes less than 5 percent.[18]

African government spending on family planning falls significantly below average compared to other regions. The overall regional government contribution to family planning services in East and Southeast Asia, for example, is nearly 95 percent.

Even allowing for the possibility of growth in government spending on family planning in sub-Saharan Africa, it is very unlikely that governments will be able to fill the gap between available resources and growing needs for services.

Does donor spending influence government spending?

The development of family planning services in Africa has been driven by donor spending on these services. It is possible that governments have diverted to other areas resources they might have used for family planning because of the availability of donor family planning funds. Whether or not they will make up for declines in donor spending by providing domestic resources is unclear. Case studies of countries where donor support has declined or been withdrawn can help settle this issue.

QUESTION #6:

Should governments and donors subsidize family planning services?

There are four arguments for government and donor funding of family planning services, described below.

Governments and donors should subsidize services to which society believes each individual should have access regardless of their ability to pay for them. Contraceptives qualify for subsidies based on this argument, since they give people more control over their reproductive lives.[19] This is probably the strongest justification for donor and government financing of contraceptive services.

Governments and donors should subsidize activities that will benefit not only the individual, but also society as a whole. Supplying condoms is an example of a service that benefits both the recipient and the community, since condom use helps to reduce the transmission of sexually transmitted diseases. Some would argue that the use of contraceptives for general family planning purposes produces additional benefits by reducing the strain on public services, environmental degradation, etc. However, many would argue that population growth may be more appropriately and effectively reduced through broad socio-economic development initiatives than through family planning services.

Governments and donors should subsidize services that help reduce poverty. Some people believe that governments and donors should subsidize contraceptives for those who would not otherwise be able to afford them. However, the cost of obtaining family planning services tends to comprise a very small proportion of household budgets. Family planning can help reduce poverty, though there are more direct and effective ways to achieve this goal.

Governments and donors should subsidize useful services that the private sector has little or no incentive to provide.[20] Contraceptive regulation, testing, and information provision should be financed by governments and donors because users cannot be charged for them; thus, the private sector has little incentive to get involved in these activities.[21] Public support for contraceptive services cannot be justified using this argument, since the provider can charge a fee to the user. Where fees are charged, the private sector potentially has an incentive to get involved in contraceptive service delivery.

QUESTION #7:

What alternatives exist for mobilizing additional funds for family planning, or for decreasing the costs of services?

It is clear that additional resources need to be mobilized to meet future needs for family planning services. There are five main options for filling the gap between needs and resources:

1. increasing contributions from donors;
2. increasing contributions from developing country governments;
3. increasing contributions from service users in highly subsidized government and nongovernmental programs;
4. encouraging subsidized service users who can afford to pay for commercial services to use them; and
5. reducing the costs of services by reducing inefficiency in service delivery.

Donor and developing country government contributions may increase somewhat, but are very unlikely to meet the growing needs. We must identify new sources of revenue and ways of providing services at lower cost. Users can pay for a higher share of the costs of the services they receive from government or subsidized nongovernmental providers. This strategy should be used carefully, however, since fees can discourage those who need services from seeking them. The financial burden on governments and donors could also be reduced if more individuals obtained services in the commercial sector. Finally, there is a range of options for decreasing the costs of services, which would free resources to make services available to more people.

The other briefs in this series explore these approaches to raising revenue and minimizing costs in more detail.

References:

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[3] Ibid.

[4] UNFPA. 1996a. *Global Population Assistance Report, 1994.* New York: UNFPA.

[5] UNFPA, 1997. *Global Population Assistance Report, 1995.* New York: UNFPA.

[6] Ibid.

[7] UNFPA, 1996a, op cit.

[8] UNFPA, 1997, op cit.

[9] UNFPA. 1995. *Global Population Assistance Report, 1995.* New York: UNFPA.

[10] Conly, Shanty R., N. Chaya, and K. Helsing. 1995. *Family Planning Expenditure in 79 Countries: A Current Assessment.* Washington: Population Action International.

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[13] Conly et al., 1995, op cit.

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[15] Conly et al., 1995, op cit.

[16] Stewart, John F. and K. Koffi. 1997. *Country Report: Estimating Family Planning Expenditures in Côte d'Ivoire, 1994.* Draft. Chapel Hill, NC: University of North Carolina and the Association Ivoirienne pour le Bien-Etre Familial.

[17] Conly et al., 1995, op cit.

[18] Ibid.

[19] Desai, Jaikishan. 1997. *The Private Sector in Family Planning Services: Demand and Supply Issues.* Draft. Washington: Futures Group International, the POLICY Project.

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[21] Desai, 1977, op cit.

About These Policy Briefs

This series of four policy briefs was written by Barbara Janowitz, Diana Measham and Caroline West. It was published by Family Health International with support from the Office of Sustainable Development, Bureau for Africa, U.S. Agency for International Development.

The briefs explore four key issues in the financing of family planning services in sub-Saharan Africa:

1) the need for additional funds for family planning in sub-Saharan Africa;

2) charging fees for family planning services;

3) expanding commercial sector participation in family planning; and

4) reducing costs and enhancing efficiency.

For more in-depth information, please request a copy of the 80-page report, *"Issues in the Financing of Family Planning Services in Sub-Saharan Africa,"* from: Publications Coordinator, Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709 USA. The report is also available in full text on FHI's Web site at *http://www.fhi.org.*